MINNESOTA MAXILLOFACIAL & ORAL CONSULTANTS, P.A.

PATIENT REGISTRATION FORMS

(Please print) Today's Date: _____

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
Last *First* *M. Initial*

Preferred Name/Nickname: _____ Sex: M F Social Security # _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ May we contact you at work? Y or N

If a student, what school are you currently attending? _____

Email Address: _____ May we contact you via email? Y or N

Spouse/Emergency Contact: _____ Phone: _____

General Dentist Name: _____ Orthodontist Name: _____

PERSON WHO IS FINANCIALLY RESPONSIBLE

Minnesota Maxillofacial &Oral Consultants, P.A. is legally required to hold the parent requesting treatment for their child responsible for fees for services rendered

Name: _____ Date of Birth: _____ Sex: M or F
Last *First* *M. Initial*

Relationship to Patient: _____ Social Security #: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

INSURANCE INFORMATION

**Our office is not contracted with Medicare and cannot bill for services rendered in our office. Payment is due in full for all Medicare related patients. Is the patient covered by Medicare or a Medicare replacement plan? Yes_____ No_____*

DENTAL INSURANCE PLAN(S):

Primary Ins Co: _____
Claims Address: _____
ID #: _____ Group # _____
Policy Holder Name: _____
Address: _____
Relationship to patient: _____
Date of Birth: _____
Social Security #: _____

Secondary Ins Co: _____
Claims Address: _____
ID #: _____ Group #: _____
Policy Holder Name: _____
Address: _____
Relationship to patient: _____
Date of Birth: _____
Social Security #: _____

MEDICAL INSURANCE PLAN(S):

Primary Ins Co: _____
Claims Address: _____
ID #: _____ Group # _____
Policy Holder Name: _____
Relationship to patient: _____
Date of Birth: _____
Social Security #: _____

Secondary Ins Co: _____
Claims Address: _____
ID #: _____ Group #: _____
Policy Holder Name: _____
Relationship to patient: _____
Date of Birth: _____
Social Security #: _____

FINANCIAL AGREEMENT

The following payment options are available to you for your treatment or services:

1. Receive 5% savings if you pay in full today with CASH or CHECK. This does not apply if you are submitting claims to insurance or paying by Credit Card.
2. If you have insurance, we may collect an estimated co-pay of 20% on the day of your treatment or services. When the insurance company pays or denies your claim, you are responsible to pay any remaining balances as set forth below. Please note, many services are not covered by insurance at 80%. We recommend doing a prior authorization for all surgeries with your insurance company (time permitting). For services that are not covered by insurance, we may require payment of full balances at the time of surgery.
3. For CAPS Discount members, you must pay for all treatment or services in full to receive the discount. No other insurances will be billed.

FINANCIAL RESPONSIBILITY AND DELINQUENT ACCOUNTS

By signing below, you understand that you are financially responsible for and agree to pay Minnesota Maxillofacial and Oral Consultants, P.A. as the patient, parent/guardian, conservator, Guarantor or insured all charges not covered by the below assignment, which charges may include any medical/dental insurance deductible and co-insurance. You understand that if you are someone other than the patient, you are signing this agreement as a Guarantor. You understand that to sign as a Guarantor means that if the patient does not pay Minnesota Maxillofacial and Oral Consultants, P.A. for all charges due, you as Guarantor will be responsible for and agree to pay such payment. In cases of divorced parents, the parent signing this agreement will be deemed responsible for full payment. You acknowledge you may be required to pay in full for services the day they are rendered. You understand that, when applicable, Minnesota Maxillofacial and Oral Consultants, P.A. may submit a claim to your insurance company for payment for all or part of the cost of your treatment or services. You will be sent a statement showing all outstanding amounts owed to Minnesota Maxillofacial and Oral Consultants, P.A. 30 days after your initial treatment or services. If your insurance company has paid Minnesota Maxillofacial and Oral Consultants, P.A. for any treatment or services, it will be reflected in the statement. Additional statements for any subsequent treatment, series or overdue amounts may be sent thereafter every 30 days. You agree to pay Minnesota Maxillofacial and Oral Consultants, P.A. as follows:

i. If a claim was made to your insurance company, you must pay all outstanding amounts within 30 days of your insurance company paying or denying your claim.
ii. If a claim was not made to your insurance company or if you do not have insurance, you must pay all outstanding amounts within 30 days of the date of the statement sent to you.

You agree that any past due balances will be subjected to a late charge of 8% annually. Additionally, you agree that if any outstanding balance should become delinquent that you, the patient or Guarantor, shall pay all collection costs, which may include but are not limited to costs, disbursements, and fees, including any attorneys' fees and fees charged by a collection agency. You agree to pay a $30.00 fee for returned checks. If a Guarantor has signed this agreement, this account will always be billed to the Guarantor. You, as a patient or Guarantor, are personally responsible for payment of this account.

By signing below, you acknowledge and agree that you have read and agree to the above terms and conditions.

Signature of Patient (if over 18) or Guarantor _____ **Date:** _____

OBLIGATION TO UNDERSTAND INSURANCE. You acknowledge and agree that it is your responsibility to understand your insurance coverage. You also acknowledge and agree that Minnesota Maxillofacial and Oral Consultants, P.A. is not responsible to determine your insurance benefits or coverage on your behalf.

ASSIGNMENT OF BENEFITS. You authorize and assign any payment of dental/medical benefits by your insurance company to Minnesota Maxillofacial and Oral Consultants, P.A.

RELEASE OF INFORMATION. You authorize Minnesota Maxillofacial and Oral Consultants, P.A to release any of your written, verbal or radiographic dental/medical information for requested dental/medical reports and/or insurance claim processing.

By signing below, you acknowledge and agree that you have read and agree to the above terms and conditions.

Signature of Patient (if over 18) or Guarantor _____ **Date:** _____

MINNESOTA MAXILLOFACIAL AND ORAL CONSULTANTS, P.A.

PATIENT MEDICAL HISTORY

Patient Name: _____ Date of Birth: _____ Today's Date: _____

Why are you seeking oral surgery care?_____

Y N Any disease or illness not listed in the previous list? If so, please explain: _____

_____

Y N Are you currently under the care of a physician? If so, for what reason: _____

_____

Medical doctor name & location _____ Phone _____

Date of last visit _____ Reason for visit_____

Y N Have you been hospitalized? If so, what is the approximate date and for what reason: _____

_____

Y N Are you allergic to any medications? If so, please explain: _____

_____

Y N Are you allergic to any anesthetics? (numbing medications). Please list: _____

_____

Y N Have you or a family member had any history of anesthesia/sedation problems? Please explain: _____

_____

Y N Are you taking any medications? (Please include over the counter meds, aspirin and birth control pills):

_____

Y N Herbal supplements/Homeopathic medications. Please list: _____

Y N Do you take medication for osteoporosis/osteopenia? Oral medication Injection/Infusion

Please list the medication and frequency _____

Y N Have you had any aspirin in the last 10 days?

If a healthcare employee is exposed to my blood or body fluids through a needle stick, cut, or splash to the eye or mouth, I agree to a blood test (at no cost to me) for blood-borne diseases including (but not limited to) Hepatitis B & C and HIV/AIDS. **Please Initial:** _____

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment and care. To the best of my knowledge, the information above is complete and accurate.

_____ _____

Signature of Patient/Legal Guardian **Date**

MINNESOTA MAXILLOFACIAL & ORAL CONSULTANTS, P.A.

PATIENT MEDICAL HISTORY

Patient Name _____ Date of Birth_____ Today's Date_____

GENERAL:

Y N Fatigue/weakness
Y N Marked weight change
Y N Night sweats
Y N Persistent fever

SKIN:

Y N Rash/hives
Y N Change in skin color

HEAD:

Y N Chronic headaches
Y N Head injury
Y N TMJ pop/pain

EYES:

Y N Visual changes
Y N Glaucoma
Y N Double vision
Y N Wear contact lenses

EARS:

Y N Loss of hearing
Y N Ringing in ears
Y N Vertigo

NOSE:

Y N Frequent nosebleeds
Y N Sinus problems
Y N Hay fever

THROAT/MOUTH:

Y N Chronic sores/lumps
Y N Hoarseness/soreness

NERVOUS SYSTEM:

Y N Stroke
Y N Convulsions/epilepsy
Y N Numbness/tingling
Y N Dizziness/fainting
Y N Psychiatric treatment

BONE/MUSCLE:

Y N Arthritis/rheumatism
Y N Artificial joints
Y N Osteoporosis/osteopenia

DIGESTIVE:

Y N Hepatitis
Y N Jaundice
Y N Ulcers
Y N Change in appetite
Y N Black, bloody, or pale stools

HEART/BLOOD:

Y N Rheumatic fever
Y N Heart murmur
Y N Chest pain/discomfort
Y N Heart attack
Y N Angina
Y N Shortness of breath
Y N Swelling of ankles
Y N High blood pressure
Y N Congenital heart disease
Y N Artificial heart valves
Y N Pacemaker
Y N Irregular heart beat
Y N Heart surgery
Y N Mitral valve prolapse

Other_____

RESPIRATORY:

Y N Tuberculosis
Y N Emphysema
Y N Sleep apnea
Y N Asthma/wheezing
Y N Persistent cough
Y N Sputum (mucous) when coughing
Y N Bloody sputum
Y N Pneumonia
Y N Bronchitis
Y N Breathing difficulty

URINARY:

Y N Kidney disease
Y N Increase frequency of urine
Y N Burning on urination
Y N Bloody urine/discharge

BLOOD:

Y N Bruise easily
Y N Anemia
Y N Blood transfusion

ENDOCRINE:

Y N Diabetes
Y N Family history of diabetes
Y N Excessive thirst
Y N Thyroid Condition

Other _____

CANCER:

Y N Cancer
Location:_____
Y N Radiation treatment
Y N Chemotherapy

LIFESTYLE:

Y N Tobacco use/smoking
What form_____
How often _____
How long _____
Y N Alcohol use
Y N Recreational drug use
List: _____
Y N Steroids in the last year
Y N Sexually transmitted disease
Y N HIV/AIDS
Y N Hepatitis Type:_____
Y N Medicinal marijuana
Y N Latex allergy

Y N Pregnant/Nursing
Expected due date _____

MINNESOTA MAXILLOFACIAL AND ORAL CONSULTANTS, PA.

HIPAA Authorization For Use And Disclosure Of Health Information:

Please note, this document must be signed by patients **18 years and older**. If a parent/guardian is assisting with scheduling, billing, financing, etc. for their adult child (those considered over the age of 18) please be sure to have the patient list the applicable parties below. *We are unable to disclose any information to those not listed.*

Patient Name: _____ Date of Birth: _____

Do we have permission to disclose your **P**rotected **H**ealth **I**nformation (PHI) to individuals involved in your care?

- ☐ YES (please indicate names below)
- ☐ NO

I authorize my PHI be disclosed to the following involved in my care:

Spouse/Significant other: _____

Parent/s: _____

Children: _____

Other: _____

Do we have permission to leave a detailed message on your answering machine/voicemail?

- ☐ YES
- ☐ NO

I understand that I can request a copy of the Notice of Privacy Practices at any time which describes permitted uses and disclosures of my protected health information in further detail.

By signing this document, I acknowledge that I have read and understand this authorization.

Signature: _____

Date: _____

Office use only:

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused
_____ Communication barriers
_____ An emergency situation
_____ Other _____